Rural Healthcare Quality Network

Public Reporting and Pay for Performance

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Centers for Medicare and Medicaid Services (CMS) Quality Vision

The right care for every person every time

- **Safe**
- **Effective**
- **Efficient**
- **Patient-Centered**
- **Timely**
- **Equitable**

Institute of Medicine (IOM) “Crossing the Quality Chasm” (2001)

CMS

"... there are still lots of examples of where we are paying more than we need to for complications, medical errors and duplicative procedures".

Mark McClellan, MD, PhD

CMS Administrator

CMS..

"Today, Medicare pays the same amount regardless of quality of care. Some people would argue that in fact, the current Medicare payment system rewards poor quality". "This situation just doesn't make sense to me, nor should it to beneficiaries."
Senator Charles E. Grassley (R) Iowa
Chair, Senate Finance Committee

Why Pay for Performance?

Current system rewards quantity, not quality

Rising costs drive focus to quality, value

Align payment structure with professional goals of improved health outcomes

Congressional Actions

- Hospital Pay for Reporting
- Medicare Modernization Act (MMA)
- Deficit Reduction Act (DRA)
  - Reduce payments for hospital acquired infection?

Hospital Incentive Program

- Started in October 2003
- Premier Hospital Demonstration project
- Top 10% get 2% bonus
- 2nd 10% get 1% bonus
- Public reporting by CMS

Premier Demonstration project

- A three-year project (launched in 2003)
- Linking payment with quality measures
- Top performers identified in 5 clinical areas
  - * Acute Myocardial Infarction (AMI)
  - * Heart Failure (HF)
  - * Coronary Artery Bypass Graft (CABG)
  - * Hip & Knee Replacement
  - * Community Acquired Pneumonia (CAP)

CMS/Premier Demonstration Project

- National Participation
- Rural
- Urban
- Critical Access

  Licensed operational bedsizes range from 25 to > 1000 with an average of 351 beds

Year 1 Results

"Medicare demonstration shows that hospital quality of care improves with payments tied to quality"

"The Centers for Medicare & Medicaid Services (CMS) reported today that quality of care has improved in hospitals participating in the Premier Hospital Quality Incentive demonstration, a groundbreaking Medicare pay-for-performance demonstration project"

CMS Office of Media Affairs, Medicare News,Nov15, 2005

Financial Awards

- $8.85 million awarded to 123 top performers
- Top performers represented large and small facilities nationally

Total Payments by Clinical Area

- CABG $2,077,667
- Hip & Knee $2,060,640
- CAP $1,817,575
- AMI $1,755.902
- HF $1,139,354

Why Quality Matters

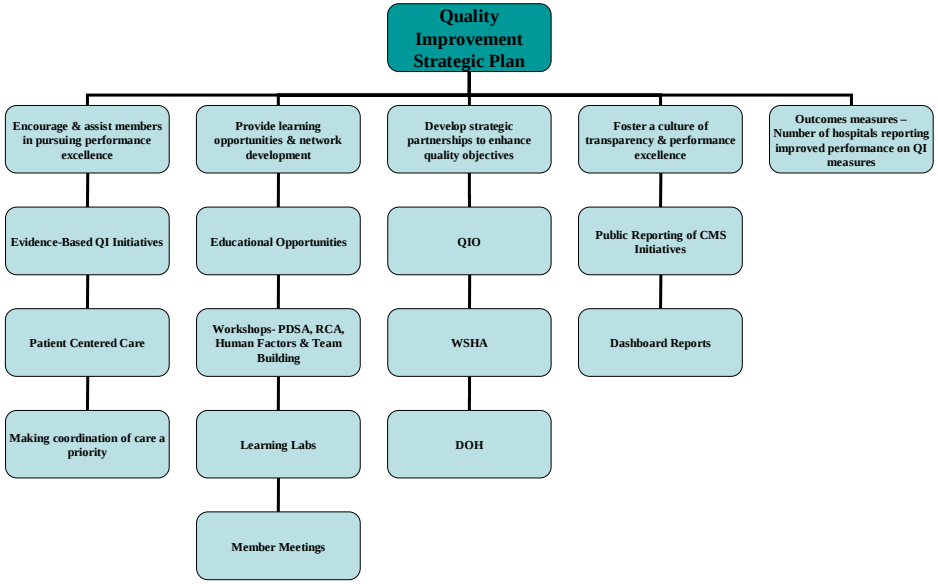
- Higher quality yields less readmissions
- Higher quality results in lower length of stay
- Higher quality yields fewer complications
- Higher quality yields lower cost

Demonstration Project: Lessons Learned From Top Performers

- “Quality” core value of the institution
- Priority of executive team
- Physician engagement
- Improvement methodology
- Prioritization methodology
- Dedicated resources
- Committed “Knowledge Transfer”

Rural Healthcare Quality Network

RHQN 2005 - 2007



Potential topics for Rural Hospital Quality- CMS

- Heart Failure
- Pneumonia
- Surgical Infection Prevention
- Emergency Department, vital signs and trauma monitoring, AMI/ chest pain
- Emergency room transfers
- Medication teaching
- Continuity of care

“Rurally Relevant Measures” University of Minnesota: Feasibility Study

- Emergency Department (ED)Transfers
- Care of AMI/ Chest Pain in the ED
- Trauma, frequency of vital signs

Results due December 2006 and will be shared with CMS

Potential Measures: AMI

- Timing of EKG
- Timing/Medication administration:
  - Thrombolytics
  - Aspirin

Potential Measures : Trauma

Was blood pressure, pulse rate, respiratory rate and time taken documented on arrival to the ED and through the first 4 hours, or until the patient is admitted, discharged, expired or transferred.

Potential Measures: ED Transfers, Documentation of:

- Nurse to nurse communication prior to transfer
- Physician to physician documentation
- Name of receiving hospital
- Patient information: name, address, age, gender
- Contact Information: significant other/and or family member sent with patient

ED Transfer Measures, cont

- Insurance/payment source information sent
- Vital signs taken and sent
- Other assessments: APGAR scores, Glasgow Coma Scale (GCS) or neuro flow sheet

ED Transfer measures, cont

- **Does Medical Record documentation indicate that the following physician communications were sent with the patient?**

  History and Physical

  Reason for Transfer/Plan of Care

ED Transfer Measures cont..

- **Does Medical Record documentation indicate that the following nursing communications were sent with the patient?**
  - a. Medication History
  - b. Allergies and reactions
  - c. Impairments
  - d. Comprehensive nurses notes

ED Transfer Measures cont..

- **Does Medical Record documentation indicate that information was sent about the treatment provided in the originating hospital?**

  a. Medication Administration Record

  b. Catheters

  c. Oral restrictions (NPO etc)

  d. Immobilizations

  e. Respiratory support provided

ED Transfer Measures Cont..

- Does Medical Record documentation indicate that information was sent on the tests and procedures that were done in the ER?
- Does Medical Record documentation indicate that the results from completed tests and procedures were sent with the patient?

Meeting the Challenges, How Can Rural Hospitals Improve Quality?

- Transformational change
- Evidence based care
- Based on national standards and guidelines
- Enabled by reliable systems
- Culture of continuous improvement
- Chronic Care model
- Patient –centered, coordinated care
- Information technology supporting processes

Issues Unique to Rural Hospitals

- Health/self-care behaviors
- Demographics- income, education, age, insurance
- Reduced scale – beds, staff, physicians, specialists
- Availability of Technology
- Importance of Geography/Linkages

Challenges to Quality in Rural Hospitals

- Culture of quality not promoted
- Lack of clinical champions
- Resource management
- Inadequate knowledge/tools to drive quality improvement efforts
- Having to focus on the short term
- Lack of, or limited infrastructure to collect/analyze data

Steps to Improving Quality of Care in the Rural Setting

- Develop a culture of quality with leadership support, training, and collaboration
- Share information, expertise, and resources (RHQN Learning Labs)
- Collect, analyze, and report data
- Focus on measures that are important in the rural setting

Steps to Improvement

- Link Quality Improvement (QI) to the mission and strategic plan
- Reorient/reinforce culture supporting CQI
- Reorient QI strategies to include population approach
- Assess community health status and needs
- Establish multi-disciplinary QI teams
- Partner with others: RHQN, QIO, DOH, IHI

Roles of Forward Thinking Leaders

- Patient AND population-centered focus
- Focus on evidence based care
- Provision of an innovative environment and resources
- Willingness to invest in redesign
- Understanding how departments relate to each other and transfer of learning across units and practices

Cont..

- Support reward and recognition systems
- Investment in their workplace to help them achieve full potential
- Investment in Health Information Technology

Transformational Change

- Change which enables a provider to deliver care meeting the goals of safety, effectiveness, efficiency, timeliness, patient-centeredness and equity

Transformation

- “ Adding wings to caterpillars does not create butterflies – it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation”

Stephanie Pace Marshall

Questions?

- Jackie Huck, Rural Healthcare Quality Network jackieh@awphd.org

- References

  CMS www.cms.hhs.gov

  Oklahoma Foundation for Medical Quality

  Stroudwater Associates: Clint Mackinney MD